INFORMED CONSENT FOR THE ADMINISTRATION OF PSYCHOTROPIC MEDICATION(S)

Name: _____ Date: _____

❒ Current Med ❒ Proposed Med

Generic Name: _____

Brand Name: _____

Daily Dose: _____

Maximum FDA: _____

Route: _____

❒ Current Med ❒ Proposed Med

Generic Name: _____

Brand Name: _____

Daily Dose: _____

Maximum FDA: _____

Route: _____

❒ Current Med ❒ Proposed Med

Generic Name: _____

Brand Name: _____

Daily Dose: _____

Maximum FDA: _____

Route: _____

❒ Current Med ❒ Proposed Med

Generic Name: _____

Brand Name: _____

Daily Dose: _____

Maximum FDA: _____

Route: _____

Comments/other:

The risks and possible side effects: Written information about possible side effects were:

❒ Given at the meeting
or
❒ Attached to this form.

The medication prescribed does include the possible side effect of Tardive Dyskinesia (TD).

❒ Yes, information given at the meeting, including information in lay persons terms.
❒ No, TD is not applicable.

The medication prescribed does include the possible side effect of Neuroleptic Malignant Syndrome (NMS).

❒ Yes, information given at the meeting, including information in lay persons terms.
❒ No, NMS is not applicable.

INFORMED CONSENT
FOR THE ADMINISTRATION OF PSYCHOTROPIC MEDICATION(S)

The purpose(s) of the medication(s), including the measurable and observable target behavior(s):

The current rate, intensity, and/or quantification of target behavior(s):

The expected benefits of the medication(s), including rate/level the medication should increase/decrease the target behaviors:

The other therapies/programs available which have been considered, tried, and/or rejected.

The estimated duration of the psychotropic medication use (not to be beyond one year):

Person to contact should questions or concerns arise:

Name: _____ Position: _____

Address: _____

City/State/Zip: _____

Telephone Name: _____ Fax Number: _____

E-mail Address: _____

INFORMED CONSENT FOR THE ADMINISTRATION OF PSYCHOTROPIC MEDICATION(S)

Information about the use of the medication(s) was provided ORALLY as part of this consent by:

_____ _____ _____AM/PM
Name of person providing information Date Time

Information was delivered: ❒ in face-to-face conversation ❒ by telephone

A person who is prescribed psychotropic medications may grant informed consent if he or she has no legal representative. If there is legal representative that person must sign.

Person giving informed consent, check all boxes that are true:

❒ I understand the information above that has been explained to me about the psychotropic medication(s) listed.

❒ I was given this same information in writing.

❒ I understand that I may refuse consent.

❒ I understand that my consent may be withdrawn at any time.

❒ I understand that the consent is time limited and expires annually.

(According to MS, section 245A.02, subd. 2b, the definition of "annual" or "annually" means prior to or within the same month of the subsequent calendar year.)

Person giving informed consent, based upon the information provided check the one box you agree with:

❒ I approve the use of the psychotropic medication(s) listed.
❒ I do not approve the use of the psychotropic medication(s) listed.
❒ I only approve as specified in my written comments.

Comments:

_____
Name of person giving informed consent (print)

_____ _____
Signature of person giving consent MM/DD/YYYY